

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS : <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:			
Medications:			Birth wt:	Wt:	%	Length:	%	Head circ:	%

Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown
Second Newborn Hearing Screen (if 2nd needed/completed): ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown

PARENTAL CONCERNS/HISTORY: How are you feeling about baby? Do you feel safe in your home?

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Breast feeding ☐ Formula: _____
☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENT: ☐ Rooting reflex ☐ Startle ☐ Suck & swallow ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Supine sleep ☐ Car seat/rear facing ☐ Infant bonding ☐ Bottle prop ☐ Passive smoke ☐ Support/who can help? ☐ Infant crying/what to do? ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Guns ☐ Other

BEHAVIORAL HEALTH SCREEN: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/parent responds positively to child ☐ Length of time infant cries ☐ Encourage holding ☐ Infant hands to mouth/self calming ☐ Other

COMPREHNSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: ☒ INDICATES ORDERED ☐ 2nd Newborn screening (5 – 10 days of age or first PCP visit) ☐ Other

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ 1st Hepatitis B vaccine date: _____ ☐ Pt. Needs immunization today
☐ Shot record initiated ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/ DDD ☐ Developmental
☐ Behavioral ☐ Specialty ☐ Early Head Start ☐ 2nd Newborn hearing screening (if needed) ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐ Yes ☐ No